

Beyond ‘trauma’

Notes on mental health in the Middle East

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This special section includes some of the works presented in an interdisciplinary workshop entitled ‘Beyond “Trauma”: Emergent Agendas in Understanding Mental Health in the Middle East’, held in September 2014 in London. In the face of a pressing need to rethink the psycho-politics of well-being and mental health in the Middle East, the event raised questions about what is at stake – culturally, historically, and politically – when mental health becomes an area of inquiry and intervention. Specifically, we aspired to bring together viewpoints that go beyond the limits of dominant global health paradigms that are characterized by an individual-centred emphasis and approaches that focus on trauma and PTSD. We hope to engage in an ethical and pedagogical examination of what we assume we know, and to ask what happens to psychiatry and mental health care paradigms as they travel. At stake are a number of conceptual frames, both in the social sciences and in psychological disciplines, that no longer seem helpful, yet remain central in mental health care practice and policy making. A critical conversation about the cultural meanings and situated experiences of psychological conditions, as well as the appropriation of diagnostic categories and theories of trauma, seems to be long overdue.

In calling the project ‘Beyond “Trauma”’, we challenge the competing disciplinary assumptions that underlie the term and that pathologize and determine the parameters of ‘healthy’ reactions to ‘unhealthy’ conditions. One concern is that ensuing diagnostic labels (such as PTSD) and classifications (such as the DSM), themselves widely contested even in Western biomedicine, individualize and de-socialize experiences and phenomena that are fundamentally social and historical. We are also sensitive to the violence inherent in the very process of identifying trauma, which entails a politics of exclusion by applying taxonomies of

experience. Such practices risk masking, erasing, and trivializing the experience of some while reinforcing the conditions that created the so-called trauma in the first place. This is not to overlook the individual burden and medical conditions that traumatic experiences inflict on individuals. As Veena Das puts it in her insightful commentary, "The issue here is not whether PTSD is real or not, but what forms do the relations among politics, law, and psychiatry take in different time-space configurations?" I would add the question: What cultural and historical forces and moral tensions shape such reality?

The idea of the workshop arose in part from frustration with the extent to which communication across disciplines and areas of expertise remains blocked. While we all agree that interdisciplinary work matters, we have yet to overcome hierarchies of expertise and intellectual territories. Interdisciplinary work is continually challenged by competing rather than converging conceptual frameworks. One aim of the workshop was to achieve an interdisciplinary dialogue in which each participant could invite others to challenge their disciplinary assumptions, in which we could all display a willingness to face conditions beyond our grasp. This section is a showcase of that dialogue. By the end of the workshop, a shared language had emerged built on mutual care and concerns. The participants came together around a deep sense of care and empathy for the human condition and the premise that health and well-being are shaped by both medical and sociopolitical forces, contexts, and histories. We believe that the tensions that different methodologies of research reveal between the mind-sets, narratives, and aspirations of different groups are valuable resources, rather than obstacles, for inclusive approaches to policy. We tried to illustrate, for example, why and how art, literature, cultural studies, and history are not only relevant to, but in fact essential for informed mental health policy making, and why psychiatry cannot single-handedly deliver positive outcomes when it is divorced from politics, anthropology, and history. Mental health, in other words, is more than a clinical matter. Furthermore, clinical categorizations have implications beyond the clinical encounter.

When affliction occurs, it can provide the context in which certain forms of life become either valorised or pathologised. Depending on what gets pathologised and what gets valorised, institutions and politicians may create or instrumentalise certain strategies of living and political projects. From Hezbollah's identity politics of solidarity in Lebanon, to Iranians' mobilization of Shi'ite frameworks during the Iran-Iraq War, to European narratives of heroism in the First World War that inhibited the acknowledgement of psychic pain, institutionalized narratives often fluctuate between the extremes of heroism and victimhood. But the space 'in between' is where individuals carve out strategies of living and construct fragments of agency.

The pieces in this section thus turn to those spaces. In drawing on ethnographic fieldwork they share a bottom-up approach to psychological well-being that goes beyond individual

clinical encounters. They illustrate how individual and social well-being are cultural, psychological, historical, and clinical constructions at once. They suggest interconnections between different locales, underscore existing institutional and professional frameworks, and highlight the challenges of multisited research. They also manifest the importance of moving away from analysis through the lens of 'resistance' in the Middle East and towards an understanding of political projects as ongoing strategies of 'living through'. The scholars here look at both conflict-ridden and post-conflict parts of the region in order to parse out the human condition that characterizes each setting. Conflict often becomes shorthand for other kinds of violence, as evident in the works of Omar Dewachi, Zuzanna Olszewska, and Hanna Kienzler and Zeina Amro, who locate violence in the complex politics of exclusion in ordinary life or around access to care. In Olszewska's article, for example, there is no military conflict, but there are various forms of structural, gendering, and institutional violence and discrimination at play against and among Afghan refugees. Rather than perpetuating depictions of unending conflict, these studies suggest a focus on what it means to live in ecologies of uncertainty, testifying to the ongoing, unfinished, and stuttered nature of memory and experience.

What, then, are people's strategies of 'living through'? Whether it is medicalization (Behrouzan), cultural work (Olszewska), consolidation of specific therapeutic structures (Kienzler and Amro), or the reconfiguration of social relations that prevent the healing of the social wounds (Dewachi), the key task is to understand the cultural resources that individuals mobilize to create strategies for living. What means are available – culturally, clinically, or historically – for people to work with or through psychological pain? At issue is discerning what helps people sustain a moral life outside rigid clinical and cultural categories, while also acknowledging, respecting, and empathizing with people's actual experiences. How can we incorporate, for example, collective acts of remembering and the powerful legacy of oral cultures into therapeutic interventions? What clinical possibilities do cultural analysis and historical accountability offer to practitioners and policy makers? Engaging with social sciences and humanities, we believe, contributes to therapeutic possibilities by helping us access the subjective experiences of inhabiting [ruptured] spaces of everyday life.

In order to access individuals' experiences and the resources on which they draw, these pieces invite us to step outside of the clinical realm and enter the world of cultural work. Zuzanna Olszewska approaches poetry as a generative space that provides capacities for both experiencing and expressing. We hope to invite similar explorations on the interconnection between the personal and the political, the intimate and the shared, from the humanities and arts. Such capacities exist in art and literature precisely because they embody lived historical experiences and provide a window into different structures of feeling. Moreover, these spaces offer individual and collective capacities for the freedom of fiction

and dreaming, which in turn make possible claims to historical experiences and demands for justice and accountability, while exploring what may come next. Artistic and literary expressions, filmic and visual mediations, activism, and various forms of cultural production allow for alternative individual and collective histories to evolve beyond institutional forms. In doing so, they offer possibilities for healing, community building, and re-assimilation. In this spirit, these pieces challenge several binaries – patient-practitioner, global-local, and cultural-biological – by incorporating the situated knowledge of practitioners, the understanding of whose experiences cannot be divorced from the conditions in which they live and work. A first step thus would be to evaluate the current state of mental health care systems that are in place, the struggles and opportunities of psychiatry's interactions with various Middle Eastern societies and their medical pedagogies, and the ethical stakes of researching the pain of others. This requires a critical assessment of the role of the outsider in such ecologies of uncertainty.

These pieces also aim at shifting lenses and challenging stereotypical representations. Rather than understanding the region through the lens of 'religion' for instance, they focus on asking what parts of religious and cultural practices are mobilized to create moral frameworks, and why. Many of us share a disappointment with representations of the region in which it is repeatedly essentialized, misrepresented, and commonly reduced to 'conflict', and the ethics of engagement such representations engender. What do we even mean when we talk about 'the Middle East'? How much do we know about its various health care infrastructures and diverse ways in which mental health and well-being are understood, practiced, and conceptualized? The speed with which the scene is changing, even since our London meetings in September 2014, both urges and warns against quick analysis. It calls for thinking about long-term, in-depth, and interdisciplinary approaches that go beyond analysing everything Middle Eastern through the lens of religion or conflict.

Sadly and inevitably, however, a portion of this project must engage with the afterlife of various wars in the region, many of which have turned from wars to prolonged states of endless chaos. The Iraq War, for instance, has become shorthand for the aftermath of an illegitimate invasion preceded by and extending earlier conflicts. Prior to 2003, Iraqi society had already been in a state of affliction for decades; the 1980 to 1988 Iran-Iraq War, the 1991 Gulf War, and decades of sanctions had created generations of lived war. Since 2003, alarming rates of mortality, disability, and displacement have been overshadowed by other catastrophes. It is estimated that over four million Iraqi children lost their parents after the 2003 invasion. More recently, millions of Syrian children have been displaced and left out of schooling. The condition of children alone qualifies as an emergency, a humanitarian crisis urging provisions for medium-term and long-term mental health care policies.

The 'Beyond "Trauma"' workshop was held in the immediate aftermath of the 2014 Gaza war. Over the past year, millions of displaced refugees from and within Syria have suffered the loss of their homes, communities, and livelihoods. Rapid transformations in the region, including the entrenchment of the so-called Islamic State's violent methods for obliterating cultural identity and inflicting atrocities upon civilians, only highlight the urgency of this conversation. There is a need for our sustained and committed attention to individuals' and communities' sense of well-being and integrity. Beyond the horror of these acts lie important reminders about what remembering and being remembered means when moral textures of societies are disrupted and structures of reverence and remembrance are obliterated.

At a more practical and immediate level, the question of humanitarianism is an urgent one that anthropologists and other scholars have investigated critically. At our event, we juxtaposed critiques of the humanitarian enterprise with the undeniable yet pragmatic need for it, as forwarded by practitioners Rita Giacaman and anthropologist Sa'ed Atshan, whose works are not included in this issue. But they enriched the ensuing debate by challenging the assumption in critical analysis that the humanitarian 'gift' is inherently oppressive; instead they highlighted its capacities for also creating solidarity. Hanna Kienzler and Zeina Amro further this critique by asking questions about transitioning from emergency interventions into long-term sustainable ones. We hope to advance this line of inquiry by inviting more scholars and practitioners to engage in critique while appreciating the complexities of practice. We were extremely privileged to have as our keynote speaker Jennifer Leaning, the distinguished human rights scholar and the director of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University. As an expert in public health rights-based responses to humanitarian crises, she addressed several key issues pertaining to practical predicaments, thereby complementing our debate by providing a situated insight into the ethics and complexities of humanitarian engagement. 'The humanitarian enterprise is still necessary though deeply flawed', said Leaning, setting the stage for a lively, critical, and truly interdisciplinary debate at our event. (Her keynote address is published in this special section as delivered in London on 27 September 2014.)

It is my hope that we grow in numbers, as this section reaches out and extends our call to more scholars, practitioners, PhD students and researchers, policy makers and others who share our concerns.¹ For now, I would like to thank the participants and contributors to the workshop: Nadjé Al-Ali, Sa'ed Adel Atshan, Veena Das, Omar Dewachi, Rita Giacaman, Hanna Kienzler, Lamia Moghnieh, and Zuzanna Olszewska, as well as our wonderful

1 For more information about the workshop and its participants please see <https://beyondtraumaproject.wordpress.com/2014/09/29/a-first-step-taken/>.

audience and the academics, physicians, psychoanalysts, and students who joined us on the day. I would also like to thank Veena Das and Michael Fischer for their insightful commentaries published here. I am also grateful to the Wellcome Trust and the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University for funding the initial event that resulted in the publication of this collection, and for the support of Professor Nikolas Rose, the Head of the Department of Social Science, Health and Medicine. We greatly appreciate the support and hard work of the editorial team of *Medicine Anthropology Theory*, particularly Vinh-Kim Nguyen, Eileen Moyer, and Erin Martineau, for their recognition of the urgency of this debate and for accommodating our section in this issue. We look forward to expanding this working group across sites and disciplines, and welcoming scholars, practitioners, and policymakers with expertise in different regions of the Middle East.

Medicalization as a way of life

The Iran-Iraq War and considerations for
psychiatry and anthropology

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Abstract

Most debates on postwar mental health focus on clinical evaluations of veterans' and civilians' individual experiences of wartime 'trauma'. But the psychological afterlife and the social discord that wars create cannot be reduced to a clinical artifact of individual trauma or be divorced from the historical and cultural meanings that it carries. Generations of war children will continue to remember, process, and work through cultural changes that quietly inscribe past war experiences in their daily lives. This article examines one such cultural shift, namely the medicalization of the memories of the Iran-Iraq War. It illustrates how individuals' PTSD-like symptoms or alleged *depreshen* turn the seemingly desocializing act of medicalization on its head, and how diagnosis can become a cultural resource to resocialize the war in the sanitized language of biomedicine. It further suggests that moving beyond an individual and clinical rendition of trauma requires the integration of an anthropological understanding of illness and its cultural situatedness into medical pedagogies.

Keywords

trauma, memory, psychiatry, postwar mental health, PTSD

Almost three decades after the end of the Iran-Iraq War, Iranians continue to grapple with its health-related consequences. The 2014 Health Impact Assessment report published by Medact, an organization of health professionals engaged in research and activism, is among the more recent reminders of how the war lives on, and causes suffering, across generations. The report also illustrates why systematic health impact assessments, even though often focusing on epidemiological studies, should be an integral part of any attempt to assess the impact of war on civilians, if not a crucial prerequisite for preventive and interventional initiatives (Tirman 2015; Birch et al. 2014). Indeed, epidemiological data are useful, but they need to be interpreted within proper conceptual frameworks to ask what they reveal and what they mask. What is necessary is a critical examination of the cultural meanings that shape individuals' experiences of diagnostic categories and the standards and models on which they rely.

Such anthropological and cultural analysis of the experiences represented by quantitative data and standardized diagnostics is not merely a secondary investigation into a given medical construction; rather, it sheds light on how medicalized experiences (such as illness) are socially and medically constructed and inhabited, how they are made meaningful, and how life is lived around and within them. It is necessary to approach the psychological afterlife of war as both a medical and a social experience, not only in assessing the impact of war, but also in thinking about inclusive therapeutic interventions. Reflecting on ethnographic findings, I extend the question of the psychological impact of war on veterans to the impact on their children, now adults, in order to frame a set of questions, provocations, and lines of inquiry, and to revisit the conceptual frameworks of 'trauma' in the psychological sciences and 'medicalization' in anthropology.¹ These are preliminary thoughts and aim to serve as a call for dialogue.²

The Iran-Iraq War and the 'War of Cities'

Three decades later, the memories of the Iran-Iraq War have not left Iranians, nor has the collective feeling that the international community and Western governments abandoned them during the war, provided Saddam Hussein with arms and intelligence, and overlooked their calls for accountability in its aftermath. The Iran-Iraq War, or as it is called in Iranian

1 'Medicalization' is used to describe conditions in which previously nonmedical phenomena are brought under the purview of biomedicine and often turned into disorders. For an overview of the historical and conceptual trajectories of the term please see Conrad and Waggoner 2014.

2 The findings discussed in this article are taken in part from a larger ethnographic project that I conducted between 2005 and 2012 (Behrouzan 2016).

public culture ‘the Sacred Defense’, resulted in over one million deaths on both sides, with up to five hundred thousand Iranian deaths estimated.³ Reports from the Martyrs Organization also estimate that there are over 550,000 *jānbāz* (war-disabled veterans) and over 42,000 former prisoners of war in Iran, of whom 120,000 are registered as chemically injured veterans (*Sacred Defense News*, ‘Latest Statistics on Veterans’ Families’, 21 October 2013).⁴ Figures are only reliable in so far as they represent registered veterans. But in addition to the 43,000 documented *jānbāz-e a’sāb va ravān* (psychologically inflicted veterans), and the 7,200 patients with serious psychiatric disorders, a growing number of spouses and children of veterans are experiencing psychological symptoms such as depression and anxiety. To address this situation, the Veterans Organization has recently introduced the ‘endurance [*tāb-āvary*] initiative’, which aims to equip families and caretakers with proper coping skills (*Basij Press*, ‘New Training for 43,000 Veterans’, 5 January 2015).⁵ Among these relatives, spouses of veterans who suffer from posttraumatic stress disorder (PTSD) have been reported to experience severe psychological symptoms (Taghva et al. 2014), while the ‘overall life satisfaction, subjective well-being ... of wives of Iranian disabled veterans’, is reported to have diminished due to the loss of ‘their natural homeostasis’ (Yousefi and Sharif 2010, 69). The children of war prisoners reportedly suffer increased rates of major depression and general anxiety (Razavi et al. 2012).

Attention to postwar psychological well-being has often focused on veterans and POWs. But the afterlife of the Iran-Iraq War is hardly limited to the experiences of returning veterans. For example, an increased rate of psychological disorders has been reported among war-displaced families in western Iran (Hashemian et al. 2006). Epidemiological studies conducted by health professionals have shed light on the often-overlapping physical and psychological conditions among veterans and civilians, particularly those exposed to mustard gas and those who struggle with chronic illness and long-term psychological conditions (Hashemian et al. 2006; Khateri et al. 2003; Falahati et al. 2010; Razavi et al. 2014). Studies suggest that in the decades since Saddam Hussein’s brutal use of chemical weapons on Iran’s civilian population, fertility has been hampered and the risk of congenital and developmental conditions has increased (Abolghasemi et al. 2010). There is also evidence of increased

3 *Encyclopaedia Britannica Online*, ‘Iran-Iraq War’, accessed 26 November 2015, <http://www.britannica.com/event/Iran-Iraq-War>. Existing estimations and mortality reports for the Iran-Iraq War are constantly contested and vary across sources. See Murray and Woods 2014; Chubin and Tripp 1988; Khoury 2013 for historical overviews; Khoury’s historical analysis of the Iran-Iraq war and the Iraqi perspective is particularly insightful for comparative evaluation.

4 <http://www.defapress.ir/Fa/News/4855>

5 <http://basijpress.ir/fa/news-details/41691/>

psychological symptoms among all civilians affected by war (Karami et al. 2013; Roshan et al. 2013). While most epidemiological studies have focused on surveys of diagnostic categories, some have examined the role of spirituality, social support, life satisfaction, and ‘constructive coping strategies’ in improving the psychological well-being of veterans and their families (Ebadi et al. 2009; Hassankhani et al. 2009; Aflakseir 2010).

But what forms of actual experience – lived lives – do epidemiological figures represent? In the psychological afterlife of social ruptures such as the Iran-Iraq War, an alternative history of loss or neglect is written. Iranians commonly share the perception that the international community has overlooked their suffering. These alternative histories and collective emotional states contribute to the emergence of medical as well as cultural forms that outlive wars. Similarly, the creation of compensatory structures, social categories, and cultural labels such as *‘jānbāz’* (war-disabled veteran) produces both relief and restriction: while facilitating recognition and care, these forms of life also interact, in the long term, with other dynamic modes of perception and interpretation that prevail in the postwar era. Many Iranian veterans report facing resentment and neglect when returning to society; others struggle to qualify for registration and compensation. Many veterans were reluctant to claim stigmatized compensatory benefits, some lost them after hesitating too long; others found themselves ideologically distanced from their children and the society to which they returned (Behrouzan 2016). These invisible wounds escape quantitative measurements and diagnostic classifications such as those formulated in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Indeed, we already know from the experiences of wars elsewhere that the cultural legacies of war persist across generations. But we rarely incorporate such postwar sociopolitical and cultural transformations in mental health discourses, particularly in the Middle East.

The Iran-Iraq War also transformed Iranian society by creating new forms of civilian life, and, in the longer term, new generational cultures and aesthetics among those who were children during the war. When wars are over (if they ever are), not only do their physical and psychological wounds live on, but their internalized memories too continue to return, whether in the form of perceived pathology or in other cultural expressions. They affect individual and social well-being and determine the relationship of the inflicted society with the rest of the world. For example, during what became known as the ‘War of Cities’, civilians in twenty-seven Iranian cities experienced, between 1984 and 1987, five episodes of missile raids that destroyed neighborhoods and livelihoods, and killed thousands of civilians, particularly in Tehran and Dezful (Khaji, Fallahdoost, and Soroush 2010). Even among those who were children during the war, these missile attacks on major cities, along with the brutal use of mustard gas and nerve agents on civilians, occupy a central place in collective memories and psychologies. The self-identified ‘1980s generation’, in particular, repeatedly

returns in its artistic and cultural expressions to the war's sensory prompts (for example, the sound of sirens) in order to claim their cultural aesthetics, identity politics, and generational sensibilities (Behrouzan 2016).

The Iran-Iraq War, in sum, is an undeniable part of the psychological and cultural worlds Iranians continue to inhabit. Its invisible wounds still hurt. Recently, for example, commemorative ceremonies sprang up in several cities as Iranian rallied around the return of the bodies of 175 fighting Iranian divers who had been buried alive with their hands tied (Karimi 2015). Iranians' collective sentiments are today informed by the sacrifices of the war, commemorations of its losses, and an increasing awareness about its mental health impact. How can we then approach diagnoses such as PTSD or depression in this deeply wounded context? Would such diagnoses be sufficient to capture the postwar subjective experiences that mental health policies aim to address?

Reading PTSD, clinically and anthropologically: The 'I' and the 'we'

Sara, the daughter of a veteran and child of a war-refugee family, juxtaposes her generational sensibilities with those of her clinical and psychiatric diagnosis: PTSD. 'You see', she says, 'my generation strives for happiness. We are the children of the war and all its consequences. ... I know I don't look *depress* or shell shocked! [laughing]. But looks can be deceiving'.

The year was 2008. In my interviews with self-medicalizing young Iranians, the term 'generation' surfaced one way or another, as did references to the Iran-Iraq War, imposed economic sanctions, and other such legacies of the 1980s. Displaced by the war from one of the southern cities, Sara and her family relocated to Tehran when she was in elementary school. Her father was an engineer who joined the front for just under a year in 1983. He lost his right leg and underwent several operations, eventually recovering and establishing a career in Tehran, but he was 'never the same person', Sara recalls her mother saying. He has, in the following years, begun to struggle with respiratory conditions that are likely caused by exposure to mustard gas, but his case has not been confirmed (and is further complicated by the fact that he is a smoker). His medical appointments, his 'PTSD' episodes, and his hospital admissions, Sara tells me, are a huge part of her childhood and adolescent memories, as is the tacit awareness of his temper, his sensitivity, his occasional anger: 'Somehow, I knew I should keep the volume down when watching the television, listening to music, or playing Atari with my cousin. Loud and bursting noises bothered him; he could lose his temper'. Sara also has very vivid memories of staying up all night praying for her father's safe return, of worrying about losing her mother, of the air raids that hit her best friend's house, and of the chaos around their move to Tehran. She remembers attending a

new school, where her cousin was already a popular student; missing their old house when they first moved into the small apartment they rented in her uncle's neighborhood; and the nights spent in the basement shelter where their neighbors shared snacks and stories and rumors and gossip, carrying on underneath the missile attacks. One neighbor was reportedly killed when visiting her mother's house that was hit by a missile; another worried whether or not to postpone their son's wedding. Myriad scenes and sounds return in her dreams, and quite frequently; it is 'a lot of *toromā* [trauma]', she admits. 'Things were happening too fast, and I was too young to process them. And remember, my experience is nothing compared to those whose houses were bombed or whose fathers were martyred'.

Yet Sara's individual childhood memories are frequently anchored in the shared experiences of a collective 'we'. Generalizations about '*nasl-e man*' (my generation), just one of the many names for the self-titled 1980s generation (*dabeh-ye shasti-bā*), signify consensus on a shared experiential identity, but they can hardly be taken at face value. Nor can the Persianized terms '*depress*' or '*toromā*' be taken as the direct translation of their clinical 'equivalents'. Sara has been on antidepressants on and off for the past two years. She was diagnosed with depression after a series of losses and conflicts in the family, and began taking medicine; she stopped, but then chose to resume taking it, although without a prescription: 'It helps me go through life when I am down. I am not a victim; *depresben* is inevitable when you are a graduate struggling with unemployment, when you still live with your parents, but your values are different from them. ... I cannot change what goes on around me – people around me are angry and frustrated – but I can fix myself and the chemicals in my brain'. With her bright red lipstick and heavy makeup, Sara looks nothing like the clinically depressed patients I had known in my psychiatric rotations in the late 1990s. But that is precisely what differentiates her *depresben* from major clinical depression as classified by the DSM.

In Iran, postwar generational forms and cultures have taken a medicalizing turn, and not solely because of the efforts of clinical practitioners or mental health awareness campaigns: young Iranians commonly interpret well-being as historically intertwined with their generational experience of the Iran-Iraq War. One of the ways they articulate this connection is in the language of psychiatry. The broader context of this medicalizing trend was a psychiatric discourse that entered the media in the 1990s and became assimilated into daily life. I have written elsewhere about the emergence of this new way of talking about life and its cultural and medico-historical trajectories (Behrouzan 2016). But, in short, during the postwar years the status of psychiatry as a medical discipline was revived, both in academia and in the media, and a public psychiatric language (Persianized terms such as '*depresben*', '*esteress*', '*toromā*', '*depress*', and '*dep zadan*') gradually populated the national media and the Persian lexicon.

Indeed, language was both an expression and a shaper of experience; Sara's comments reflect this growing willingness among youth to identify with illness. She recalls her initial diagnosis of PTSD and depression: 'On the one hand, I wasn't sure how I felt about the stigma because it meant I was not a normal person, but on the other hand, I was relieved. I knew I wasn't crazy or weird. It made sense. After all, I grew up in the shadow of a bloody war'. I have called these modes of self-creation 'psychiatric subjectivities', and described them as a performative embodiment of the biomedical discourse as part of one's articulation and interpretation of lived life (Behrouzan 2016). When asked to explain the rising rates of psychiatric diagnoses and medication in the 1990s, it is common for young individuals to reflect on the generational sensibilities and memories of the Iran-Iraq War. In their rather diagnostic interpretations of history, one thing remains constant: the moods and psychological states of individuals are commonly anchored, articulated, and interpreted in relation to a collective 'we' and various generational labels and forms.

Sara has recurring dreams 'of crashes, airplanes crashing into our house', and of episodes of fleeing or being chased: 'once with my parents; we jumped into the car and drove off. In the dream, I knew we were driving to the suburbs during the missile raids that hit Tehran'. In other dreams, she hears screams, sirens, or explosions, 'most commonly, loud cries of a big crowd; chaos, chaos'. She describes waking with a racing heart, sweating, and a feeling of panic ('I feel it in my stomach'). When I ask her what prompts these dreams, she says they come and go without notice: 'If I think hard, I can remember some of these scenes or sounds in real life, or from television, or from school. Even after we moved to Tehran, the war was always around us. My generation is who it is today in part because of growing up during the war; we had to catch up; our parents were all too busy figuring it out and keeping us safe. ... We grew up too fast. This is why we hate wars. We experienced a collective *toromā* as children'. The seamless transition from 'I' to 'we' helps her to anchor her dreams and make her experience intelligible.

Sara's reflections may not be universal, but they reveal some of the ways in which childhood memories are reconstructed, inhabited, and made meaningful. To this day, the sound of fireworks triggers in Sara very physical symptoms of panic, irritability, and shortness of breath: 'I get all these *PTSD* [in English] symptoms even if a balloon bursts next to me!' The presence of wartime cultural symbols and images in dreams and flashbacks is common among those who were old enough to remember the air raids or to be affected by the war in one way or another. Those memories create feeling states, reflexes, and symptoms that feel very real even today (Behrouzan 2016; Behrouzan and Fischer 2014).

For Sara, the war is an integral element of her identity, as well as that of her generation. On the one hand, drawing on the psychiatric language that became normalized in society since the 1990s, she clinically diagnoses and medicalizes life experiences that are socially and

historically structured. Simultaneously, she historicizes this affliction by situating it in her childhood memories of the war: 'I grew up knowing that my father could die any minute, that our house could be bombed any minute. It is a miracle that I am still a functional individual after being surrounded by death and mourning all my childhood!' Like many of her peers, Sara repeatedly sprinkles her recollections with humor. Humor is a common narrative strategy among her generation, particularly when mobilizing such memories outside the medical domain, in cultural productions and artistic expressions, and in their creation of various generational labels, identities, and cultural forms. Invariably, they create a generational theme by drawing upon songs, films, works of art, and cultural symbols that persistently underscore the experiences of 'their generation'.⁶ Similarly, their narratives of 'illness' too are shaped by medicalizing desires that explicitly spring from strong memories of sociohistorical ruptures. Sara traces her PTSD, partially, to those 'shared' memories and their repeated return: 'No one understands or remembers what we went through. Unless they were there'. There is an urge to remind, to challenge the forgetfulness of a world that has moved on.

She persistently 'remembers' the war, even though she was too young to have actual memories of the battle itself. Sara's medicalization of her memories and the feeling states they create is culturally generative. In creating a generational meaning for her diagnosis, she pushes forward particular forms of sociality and kinship. Along with her generational peers, she demands recognition not only of her predicament but also of the historical injustices brought about by the war. There are lessons here not only for psychiatry in societies after such ruptures, but also for the post-Foucauldian analyses of medicalization: Sara's PTSD-like symptoms or alleged *depreshen* turn the seemingly desocializing act of medicalization on its head. In post-1980s Iran, psychiatry created a language for 'working through' and inhabiting the experience of the war. Diagnosis thus becomes a cultural resource for these youth who resocialize the war in the sanitized language of biomedicine. In medicalizing their state, they make larger generational claims for recognition and carve out spaces for agency, even if in fragments.

Medicalization as a cultural resource

Wars often result in the development of new forms of knowledge and expertise. Psychiatry thrived in Iran after the Iran-Iraq War and was advocated in the 1990s via a media-based

6 The boundaries of these generational labels remain contested, which primarily manifest in rivaling claims to these labels. I have examined these generational forms and discussed their cultural trajectories in length elsewhere (Behrouzan 2016).

discourse aimed at raising people's awareness about mental health issues. In the process, it helped to normalize a clinical language within everyday Persian. Alongside 'her generation' (wherever its boundaries are drawn), Sara makes the war's psychological afterlife meaningful by using the cultural languages available to her, one of which is the normalization of this particular clinical language and Persianized terms such as '*toromā*', '*esteress*', '*depreshen*', and 'PTSD'. As one of the many affective strategies that Sara's generation employs, her medicalization of war memories serves identity politics: her diagnosis serves as a cultural resource for historicizing her experience and creating a generational voice that demands justice and accountability.

But why would an individual willingly identify with a psychiatric illness? What is the appeal of self-naming in the language of pathology? While the DSM remains the most commonly used diagnostic tool in Iranian psychiatry, terms such as '*depreshen*' or '*toromā*' do not fit into global paradigms of mental health (Behrouzan 2016). Sara's undifferentiated translations of such clinical terms and her generational identifications with a historical etiology complicate conventional critiques of medicalization in anthropology. Rather than a top-down biomedical construction or an ideological representation (as elaborated in Young's [1997] classic work on North America), in Sara's context PTSD emerges in the juxtaposition of psychiatry with several cultural and psychological paradigms, including Shi'ism, mysticism, and its transcendental formulations of suffering, melancholic and literary resonances of an imposed war, poetic renditions of sadness, and globalized aspirations for 'happiness'. Understanding its significations thus requires cultural investigations into the symbolism that underlies civilian interpretations of PTSD. It also necessitates gaining historical insight into the emotional and cultural trajectories of the ways in which Iranians perceive their own affective structures in relation to Shi'ism, mysticism, and gnosis (Good, Good, and Moradi 1985; Fischer 1980; Fischer and Abedi 1990; Beeman 1988).

The trajectories of Iranian psychiatric mindsets are indeed too complex to be accounted for by top-down analyses of biomedical hegemonies such as those common in debates on global mental health (Summerfield 1999); such a linear analysis wouldn't account for the agency with which people inhabit their experiences of loss. Of course, there are differences between individual experiences of PTSD. Sara's was constructed in the intimate space shared by the 'I' and the 'we'. It is culturally significant in that, by being situated in relation to collective losses, Sara's invocation of PTSD tells a story of how generations are built around shared experiences, how history is psychologically reconstructed, how social anomie is perceived in the collective mind, and how, above all, pathology becomes a cultural resource for demanding justice. Her PTSD, or rather her identification with PTSD, became a way of life (one among many ways) and a channel through which to interpret and articulate emotions and memories that are indescribable. Her diagnosis of PTSD has also legitimized medical care and social relief and reduced the stigma of mental illness. Locating illness in her

individual brain, and thus seemingly desocializing her historical experience, Sara's rendition of her PTSD nonetheless creates new socialities, kinship, cultural aesthetics, and generational forms. It responds to the collective desires and forms of generational identification that are centered on remembering the Iran-Iraq War beyond institutional narratives, and on the role it plays in the identity politics of her generation. A clinical approach to Sara's PTSD would detach it from its cultural and social meanings. For Sara, medicalization matters because it helps to make sense of and connect her to the desires, claims, and hopes of a young, educated, dynamic population that now has access to the culturally legitimated language of psychiatry.

While the medicalization of historical experiences may undermine individual agency and the cultural meaning of such experiences in other settings, this is not necessarily the situation anthropology faces today in the so-called Middle East.⁷ The Iranian postwar psychiatrization of generational memories illustrates how people may find in diagnosis and medication forms of clinical legitimation that may allow for historical and generational recognition (Behrouzan 2016). As such, the inscription of loss into daily life (Das 2000, 2007) and the embodiment of its cultural symbols can take a medicalizing turn, but cannot be solely captured by universalizing medicalization theories in anthropology nor the diagnostic criteria of the DSM. Medicalization can exceed these, serving as an instrumental call for justice and a creator of new socialities, generating new cultural discourses (Kleinman 1989; Kitanaka 2012; Scheper-Hughes 1992; Fischer 2003). Might we then consider pursuing a situated anthropology of the 'medicalized' (rather than of the medicalizing forces of biomedical hegemonies), one that is sensitive to individuals' historical and generational desires for justice?

Beyond trauma and the clinical encounter

To respond to the psychological afterlife and the social discord that wars create would require more than just the clinical apparatus, in that such discord cannot be reduced to a clinical artifact of individual trauma or be divorced from the historical and cultural meanings that it carries.⁸ The clinical diagnosis of PTSD, itself contested in Western scholarship, is

7 Anthropological critiques of how psychiatry operates have often either underscored the biomedical and pharmaceutical hegemonies that trivialize individuals' subjective or historical experiences (often through the prism of governmentality), or pointed to the colonial instrumentalization of psychiatry in non-Western contexts (Biehl and Locke 2010; Biehl 2005; Healy 1997; Conrad 1992; Conrad and Potter 2000; Szasz 1997; Keller 2007; Kleinman, Das and Lock 1997; Young 1997).

8 See Behrouzan 2013.

situated in its own cultural and ideological history. It regards the traumatic memory as the problem and thus aspires to remove excess memory.⁹ But Sara's example reminds us that each cultural and historical setting creates its own demands, insisting on various forms of remembering, and persistently putting justice and recognition at the center of their commemoration. They urge us to engage with memory, not just individually, but also in its collective and generational forms (Behrouzan 2016).

Sara's *PTSD* is relational, and it is impossible to understand without rewinding to how the war was experienced by her father and her family. It encompasses several layers of a ruptured and unfinished experience that started with her father's injuries and stress disorder and her family's relocation decades ago. The clinical lens is not sufficient for capturing them. But these layers of experience can be traced elsewhere; they are compiled and reconstructed in a range of cultural productions and artistic expressions such as those in the 'Sacred Defense' genre of Iranian cinema, which serves as a window into her father's generational experiences of loss, solidarity, and pride (Naficy 2012; Fischer 2004; Behrouzan 2016). The complex processes of reintegration and reassimilation, particularly for veterans who were chemically injured or suffered chronic illnesses, have been depicted in postwar films such as Hatahnia's *Glass Agency* (1998) and *From Karkheh to Rheine* (1992), Panahi's *Crimson Gold* (2003), and a large body of literature, film, documentaries, and cultural productions that followed in the 1990s. In her ethnographic documentary *The Skin That Burns*, for example, Bajoghli (2012) provides a compelling account of the experience of a *jānbāz* who struggles with health issues thirty years after the war. Like filmic and artistic recollections, literature too provides entry points into the ways that life transformed across different generations: from earlier war novels such as Esma'il Fasih's *Zemestan-E 62* (1987), to post-1990s works like the award-winning novel *A Scorpion on the Steps of Andimeshk Railroad Station* (Mortezaeian-Abkenar 2006), the entanglement of faith, fear, anxiety, ambivalence, and doubt provides an alternative narrative of the psychological residues of the Iran-Iraq War. More, the creation of new institutionalized forms of personhood in the aftermath of the war (for example, *shahid* (martyr) and *jānbāz* (disabled veteran)) extended beyond veterans and martyrs to their spouses and kin. For women and children in particular, this required the assimilation of specific forms of conduct and responsibility, and later led to various cultural forms among postwar youth (Zahedi 2006; Khosrokhavar 2002, 2004).

In the 1990s, the proliferation of work in poetry, literature, and film served postwar generations as a site for subjectivity work and memory work. Reflections on the contrasts

9 Alan Young (1997) has written about the ideological contexts that gave rise to the consolidation of PTSD as a diagnostic category in the aftermath of World War II and the Vietnam War. Also see Fassin and Rechtman 2009 for a historical trajectory of 'trauma' discourses and their limitations.

between generational experiences of the war, between ‘now’ and ‘then’, were spoken back to the recovering society. These works have been the subject of scholarly analysis in the humanities (Khorrami and Vatanabadi 2000; Khorrami and Shirazi 2008; Ghanoonparvar 2009; Rahimieh 2003; Moosavi 2015). But since they provide alternative and complementing narratives to the narratives of medicine and psychiatry, they need to be brought into a rigorous conversation with debates on postwar mental health and psychological well-being. They ought to be read not only as text, but also as the context around mental health discourses. In other words, cultural expressions should be valued and engaged with, not as mere examples, but in their capacities as projection screens that illuminate the emotional and cultural contexts in which mental health and medicalized experiences emerge and are lived through.

What is happening today in the Middle East challenges us to re-examine the boundaries of both clinical and anthropological inquiry, as well as to distinguish the myriad of conditions and issues that we have come to call ‘mental health’. The fragmented nature of experiences across the region and the multiplicity of existing pedagogical and cultural discourses call for conceptual and methodological reconsiderations within anthropology. Like the other articles in this section, this one aims to problematize psychiatry’s reliance on metanarratives of trauma that focus either on singular events or individual psychologies. Rather, the focus ought to be shifted to the perpetual ruptures and wounds that traumatic events create, and how these inform the micropolitics of everyday life and the cultural work involved therein. The clinical encounter and the universal paradigm of trauma in biomedical psychiatry inevitably fall short of capturing historical and generational sensibilities, in part because they individualize loss without concern for its sociocultural context and meaning, and in part because they universalize trauma and take for granted a form of pathology (for example, PTSD or depression) that privileges only certain forms of therapeutic intervention (Behrouzan 2016).

At best, when incorporating psychodynamic and psychoanalytic conceptualizations of trauma, the biomedical encounter may assume trauma as located in the event, universal and singular, and as that which is only grasped later in a coherent process of retelling (Caruth 1995, 1996).¹⁰ Each of these formulations has its own situated trajectory and cannot necessarily be applied universally; one size, in other words, does not fit all. Significantly,

10 I have provided an extensive critique of trauma theories and their implementations in *Prozāke Diaries* (Behrouzan 2016). Also see Laplanche and Pontalis 1988 and Radstone 2007 for a more extensive critique of dominant trends in American trauma theory, which are informed by clinical experiences and the establishment of PTSD as a diagnostic category in the third and fourth editions of the DSM.

when ‘trauma’ is dispersed through multiple layers of sociohistorical anomie and in attempts at inscribing loss onto everyday life – as Das (1996, 2007) has shown – it is no longer individual, but a shared, diffused, and unpolished construction of collective losses and processes of meaning making that relies on culturally available spaces of mourning and coping. Those spaces ought to be further integrated into mental health discourses.

To move beyond these understandings of trauma as either singular or sudden would require a conceptual framework that captures the diffusion and fragmentation of subjective experiences and the infusion of psychological ruptures into ordinary, postwar life. Clinical and anthropological empathy can converge in a form of listening tuned into the afterlife of memory and the cultures it creates. Indeed, macro-events such as the Iran-Iraq War continue to be invoked in people’s interpretations of the feeling states in which they live. But individuals’ psychological and emotional struggles to live through the afterlife of war are often overlooked in institutionalized metanarratives of war and memory. Similarly, the long-term infusion of loss and its cultural memories into the politics of daily life and of illness is hardly captured by a diagnostic category, yet those categories remain integral to how professionals and institutions assess and perceive psychological well-being.

Reflections for narrative psychiatry

I do not wish to perpetuate an overreliance on narrative at the expense of alternative forms of marking and techniques of witnessing. But in so far as the clinical encounter engages with narratives of illness, our approach to patients’ narratives can benefit from a situated cultural critique. Sara’s interpretation of her dreams in relation to her generational memories of the war (and to her father’s experience on the battlefield) provides an example for a cultural critique of psychiatry’s approach to illness narrative. Of course, the privileged position of a purely biological psychiatry has already been called into question within psychiatry itself, and the disciplinary formation of ‘narrative psychiatry’ and its incorporation of the humanities is certainly a step forward (Halpern and Lewis 2013; Charon 2001; Charon and Wyer 2008). But psychiatry’s interest in and approach to narrative is itself culturally situated, among other things, in an essentializing formulation of the individual self and the significance of its empowerment. Narrative psychiatry in its current form requires skills in ‘narrative competence’ and listening, and is primarily concerned with helping patients find functional frameworks for their narrative (Lewis 2011), thus regarding narrative as an end in itself. For Sara, psychiatric medicalization as a narrative framework uses history and its reconstruction as a plot, tying together fragmented historical experiences and giving them meaning. Understanding her experience thus only becomes possible by understanding the historical and individual desires and claims behind it. Rather than regarding narrative as an end, her narratives of ‘illness’ are a means to historical conciliation. A primarily biomedical analysis of

her medicalized condition, her symptoms, and her identifications – without cultural insight into their historical and generational trajectories and meanings – would essentialize her illness narrative, making it static and individual. This ‘diagnostic silencing’ of patients’ cultural experiences and generational memories erases the historical and political meanings that such narratives are built upon and mean to reflect (Biehl and Locke 2010; Biehl 2005). In other words, it is essential to understand what narratives of illness mobilize, how they shape experience, the cultural contexts in which they evolve, and the potent political and therapeutic possibilities they create. When social dis-order entrenches, individuals’ living strategies entail a deep knowledge of the historical situatedness of their emotional states and psychological experiences. Individuals’ narratives and experiences of illness are therefore inseparable from this tacit sense of historicity.

This is not however merely a matter of historicizing illness narratives; rather, it has pedagogical and bioethical implications. Like individual narratives of illness, medical education as an institutional form and cultural artifact is embedded in its own broader value systems and cultural assumptions that shape the professionalization of practitioners. Mental health practitioners’ ways of listening must become sensitive to not only their own cultural assumptions, but also to how institutional narratives of history interact with or contradict individual and generational reconstructions of historical ruptures. Moving beyond an individual and clinical rendition of trauma thus requires the integration of an anthropological understanding of cultural situatedness into medical pedagogies, creating a clinico-anthropological approach to symptoms that acknowledges illness as both medically and culturally constructed. To listen anthropologically, on the other hand, would be to go beyond silences and stutters and incoherencies, to invite what escapes language, and to discern the fragmented narrative strategies that individuals assimilate into their lives. Investigating individuals’ narrative strategies, cultural productions, explanatory models, and diagnostic efforts may lead us to situated and customized interventions and therapeutic innovations in psychiatry.

On a practical note, clinical training will need to emphasize that beyond any biological basis, medicalized conditions have a cultural, historical, and political trajectory in their conception and perception. These trajectories are constantly in the making across times and places, and are multiple in their experiences and interpretations. They can serve as cultural resources in coping strategies such as commemoration, thus underscoring the salience of remembering and its cultural and generational forms. Similarly, policy making for postwar mental health care could benefit from incorporating commemorative practices and investing in community building, not only on site but also at destinations where displaced individuals arrive (particularly necessary now for the growing numbers of refugees across the region).

This article is meant to be read as a set of provocations, as well as a call for conceptual and methodological dialogue across disciplines. Historically and culturally situated interpretations of illness narratives require combining clinical listening and anthropological listening, thereby alternating between the individual and the shared, the biomedical and the historical – not as dichotomies, but as moving fragments of life. Generational, cultural, and social wounds call for an inclusive intervention that prioritizes justice and accountability; they escape biomedical diagnostic taxonomies, and do not fit into orthodox frameworks that negate the medicalization of mental illnesses and its biomedical aspects. An interdisciplinary investigation and intervention into mental health in the Middle East would thus begin with breaking disciplinary boundaries, creating room for simultaneous explorations of anthropological and cultural forms, historical trajectories, psychoanalytical insights, and biological premises of neuroscience and epigenetics. It would also remain consistently committed to justice and human integrity, appreciate moral complexities, and endeavor to innovate in the face of the uncertainty and precarity of its time. Iran's experience provides possibilities for reconceptualizing some of these analytical and bioethical frameworks. The first step is to start from bottom up, and to let stories emerge from their own context and lead us toward theory. As they always have.

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Negotiating health and life: Syrian refugees and the politics of access in Lebanon



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ABSTRACT

In the context of ongoing armed conflicts in Libya, Syria, Yemen, and Iraq, it is vital to foster nuanced understandings of the relationship between health, violence, and everyday life in the Middle East and North Africa. In this article, we explore how healthcare access interacts with humanitarian bureaucracy and refugees' daily experiences of exile. What are the stakes involved with accessing clinical services in humanitarian situations? How do local conditions structure access to healthcare?

Building on the concept of "therapeutic geographies," we argue for the integration of local socio-political context and situated knowledge into understandings of humanitarian healthcare systems. Using evidence gathered from participant observation among Syrian and Palestinian refugees in Lebanon, we demonstrate how procedures developed to facilitate care—such as refugee registration and insurance contracting—can interact with other factors to simultaneously prevent and/or disincentivize refugees' accessing healthcare services and expose them to structural violence. Drawing on two interconnected ethnographic encounters in a Palestinian refugee camp and in a Lebanese public hospital, we demonstrate how interactions surrounding the clinical encounter reveal the social, political, and logistical complexities of healthcare access. Moreover, rather than hospital visits representing discrete encounters with the Lebanese state, we contend that they reveal important moments in an ongoing process of negotiation and navigation within and through the constraints and uncertainties that shape refugee life. As a result, we advocate for the incorporation of situated forms of knowledge into humanitarian healthcare practices and the development of an understanding of healthcare access as nested in the larger experience of everyday refugee life.

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1. Introduction

In the context of ongoing armed conflicts in Libya, Syria, Yemen, and Iraq, it is vital to foster nuanced understandings of the relationship between health, violence, and everyday life in the Middle East and North Africa. Recent scholarship on the region has productively examined the relationship between governance and healthcare (Batniji et al., 2014) and the nexus of armed conflict and public health (Dewachi et al., 2014). Building on these foundations, we explore relatively understudied connections between healthcare access, violence, and quotidian refugee experiences in

humanitarian contexts (Ager, 2014). As such, we ask: How do everyday political and social interactions in receiving countries structure refugees' access to healthcare? What are the stakes involved with accessing clinical services in humanitarian situations?

Drawing on Dewachi et al.'s (2014) concept of "therapeutic geographies," we argue for the integration of local socio-political context and situated knowledge into understandings of humanitarian healthcare. Using evidence gathered from participant observation among Syrian and Palestinian refugees in Lebanon, we first contend that the very humanitarian and bureaucratic procedures that have been put in place to facilitate care—such as refugee registration and insurance contracting—may at once hinder and/or discourage refugees' accessing healthcare services and expose them to more violence. Second, beyond a straightforward issue of service or treatment availability, we argue that the process

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of negotiating access should be situated within the broader experiences and practices of everyday refugee life (Watters 2001). For example, while one might receive a specific treatment, one might simultaneously be subject to various degrees of humiliation or invalidation in the broader socio-political and economic context, thus diminishing one's sense of wellbeing.

This article proceeds in five parts. First, we present our case and methodological approach. Second, we argue for the explicit incorporation of micro-level socio-political context and practice into the concept of therapeutic geographies. Third, we present a two-part ethnographic vignette in order to evoke some of the core issues with treatment access for refugees from Syria in Lebanon. Fourth, we link these interludes back to the concept of therapeutic geographies and explore how they operate on different scales. We conclude in the hope of problematizing current practices, making new conceptual frameworks available to researchers, and facilitating new therapeutic possibilities for humanitarians, clinicians, and policymakers.

1.1. *Refugees from Syria and access to health services in Lebanon*

Syrian refugees currently constitute the second largest refugee population in the world (3.88 million registered refugees) after Palestinians (5.09 million) (UNHCR, 2015b, p. 3; UNRWA, 2015, p. 1). Though approximately 23.5% of the world's refugees now live in Lebanon, Jordan, and Turkey (UNHCR, 2015b, p. 3), little research addresses their lived experience of healthcare in these evolving contexts. While scholarship on refugee and migrant healthcare access often centers on encounters in the Global North (Gottlieb et al., 2012; Koehn, 2005; McKeary and Newbold, 2010; Okie, 2007), a growing number of studies conducted in the Global South (Arnold et al., 2014; Posner et al., 2002; Rowley et al., 2006) and specifically in the Middle East and North Africa (Briant and Kennedy, 2004; Gottlieb et al., 2012) provide a useful foundation from which to build grounded insights into contemporary refugee crises. This scholarship should also be integrated with previous research that focuses on the politics of state and non-state provider organizations in the Middle East (Batniji et al., 2014; M. C. Cammett, 2011; M. Cammett and Issar, 2010; M. Cammett, 2014; Challand, 2008; Chen and Cammett, 2012; Onyedum, 2012).

Research on these issues is acutely needed in host countries such as Lebanon. Beginning largely in the spring and summer of 2012 and directly preceding the siege of the northern Syrian city of Aleppo, thousands of refugees from Syria (both Syrian nationals and Palestinian refugees from Syria, or "PRS") flooded into Lebanon (Abu Sa'Da and Serafini, 2013; Dahi, 2013). While the United Nations High Commissioner for Refugees (UNHCR) reported 126,800 registered Syrian refugees in 2012, that number rose to 851,300 in 2013 and over one million in 2014 ("UNHCR Syria Regional Refugee Response," n.d.; UNHCR, 2013a, p. 2, 2014a, p. 2; the United Nations Relief and Works Agency for Palestine Refugees in the Near East, or UNRWA, overseas care for PRS). Officials believe that several hundred thousand refugees have remained unregistered; for example, Médecins Sans Frontières surveys conducted in January 2012 and June 2013 indicated that approximately 41% of Syrian refugees were unregistered (Abu Sa'Da and Serafini, 2013, p. 72). By 2014, Lebanon "hosted the largest number of refugees in relation to its national population" in the world at 232 refugees for every 1000 people (UNHCR, 2015b, p. 3).

While many remained in areas close to the border in northern Lebanon and in the eastern Biq'a Valley, thousands of refugees also relocated to the coastal cities of Tripoli, Beirut, Sidon, and Tyre. They found housing in rurally located "informal tented settlements," slept in common shelters such as mosques, leased urban apartments, and rented rooms in Palestinian refugee camps. For

instance, in August 2013, the South Beirut districts of Chiyah and Burj al-Barajna, which house the Mar Elias, Shatila, and Burj al-Barajna Palestinian refugee camps (as well as the heavily Palestinian neighborhoods of Tariq al-Jadida, al-Da'uq, and Sabra) hosted the two largest populations of Syrian refugees in the Beirut region, at 18,143 and 10,312 people respectively (UNHCR, 2013c). By April 2014, there were 40,538 registered Syrian refugees in Chiyah and 20,658 living in Burj al-Barajna (UNHCR, 2014b).

UNRWA officials estimate that tens of thousands of Syrians have moved into the Shatila and Burj al-Barajna camps, prompting public health and socio-economic concerns (the camps' 2011 registered Palestinian populations were 9154 and 16,888, respectively) (Author conversations with Chief Area Officers and Camp Services Officers, January 2014, May 2014, June 2014; UNRWA Public Information Office, 2011). Rampant new, unregulated construction and visible overcrowding support the conclusion that many refugees from Syria are living in the Palestinian camps (Field notes, January 2014, May 2014, June 2014). Besides offering cheap housing and proximity to work opportunities, the Palestinian camps also offer a specific form of security; many Syrian refugees and PRS who have not acquired or cannot maintain legal status choose to live in these communities because Lebanese security forces do not patrol them (On Palestinian refugee camps in Lebanon see: Allan, 2013; Peteet, 1987, 2005; Sayigh, 1995; Suleiman, 1999).

The strain on the Lebanese health system has been immense (Dahi, 2013; Dewachi et al., 2014; Lebanese Center for Studies and Research, Beirut Research and Innovation Center and Oxfam, 2013; Parkinson, 2014a). For example, an April 2013 UNHCR report emphasizes that the Syrian refugee influx strained Lebanese capacities and that the Lebanese cost-sharing model consequently stretched UNHCR's own financial resources in comparison to state-paid healthcare systems in Iraq and Jordan (UNHCR, 2013b). The Lebanese Ministry of Health declared in a June 2013 press release that the hospital systems were being overwhelmed by the influx of Syrian patients and that this development posed a risk to Lebanese public health (Minister's Office, 2013). Likewise, Dahi reported in September 2013 that Lebanese hospitals in the Biq'a Valley were out of beds and that non-governmental aid organizations were running out of resources for health programs (Dahi, 2013).

The heavily privatized nature of the Lebanese healthcare system has profoundly influenced this situation. Exemplary care is available at private facilities such as the American University Hospital, but is accessible only to those with good insurance or extensive financial means. As Batniji et al. (2014, p. 350) note: "In Lebanon, the state has played a minimal part in providing and regulating health care, opening up the field to a diverse array of providers," many of them linked to political parties. Political parties frequently favor supporters and allies in their allocation of health and social services (Batniji et al., 2014; Cammett and Issar, 2010; Cammett, 2011; Cammett, 2014). One study found that joining or volunteering for a political party made a person twice as likely to receive financial aid for healthcare; the authors noted that poor Lebanese were systematically excluded from these systems (Chen and Cammett, 2012).

The system is thus informally biased against non-citizens—who do not join Lebanese political parties—as well as many Lebanese citizens with limited financial means. Perhaps unsurprisingly, a Norwegian Refugee Council (NRC) report published in March 2014 relayed that 74% of Syrian refugees living in the North, the Biq'a, and the South reported difficulty accessing healthcare (Norwegian Refugee Council, 2014, p. 15). A joint study published in June 2015 by the International Rescue Committee (IRC) and the NRC noted that 55% of Syrian refugees in Mount Lebanon and Beirut experienced difficulty accessing healthcare and that the lack of specialized services was particularly acute in the

Palestinian refugee camps (International Rescue Committee & Norwegian Refugee Council, 2015, pp. 24; 26). These arrangements stand in stark contrast to the pre-war Syrian system, where both Syrians and Palestinians had access to cheap, centralized, state-run services.

Refugees from Syria have thus entered a complex healthcare environment characterized by weak state regulation and private, politicized provider organizations where partisan activism accessible only to citizens partially determines financial access to services. Syrians who are registered with the UNHCR are entitled to subsidized healthcare through a private insurance provider that contracts with the Lebanese public system; insurance covers 75% of costs and Syrians 25%. Payment for the unsubsidized portion of care has proved a point of contention. While Islamic associations have provided some needy refugees relief from the financial burden, others have gone into debt (Lebanese Center for Studies and Research et al., 2013) or have had their identification papers confiscated by hospitals when they cannot pay (rendering them vulnerable to detainment and deportation by Lebanese authorities).

1.2. Towards a micro dimension of therapeutic geographies

The concept of “therapeutic geographies—the geographic reorganisation of health care within and across borders under conditions of war” (Dewachi et al., 2014, p. 449) provides powerful insight into shifting patterns of healthcare provision and access by building on scholarship on conflict and forced migration (p. 454). The authors’ empirical focus on transnational movement, militarisation, and regionalisation (p. 450–454) and their presentation of therapeutic geographies indicate the need to evaluate expressly multi-level (e.g. regional-city) and multi-sited (e.g. community-hospital) interactions in refugees’ health outcomes and experiences. Dewachi et al. compellingly present this perspective as a counterpoint to the more state-centric health systems framework (p. 454). Yet to take their approach a step further, “mapping” evolving therapeutic geographies should capture both broad transformations such as regionalisation and bottom-up feedback based on the situated practices and knowledge of refugees themselves (Haraway, 1988). This extension underscores the inherently variable microdynamics of healthcare access, including factors such as the local security environment and the field of (non)state providers. Yet it also, and perhaps most importantly, affords space for refugees’ own agency and resourcefulness, which are undertheorized in current conceptualizations of therapeutic geographies.

On this note, global public policy approaches emphasize the importance of understanding complexity and scaling; situations such as refugee crises must be understood as involving multiple policy and political domains, state and non state actors, and local, regional, and national contexts (Miller, 2014, p. 503). Much scholarship on medical humanitarianism and refugee health supports a similar perspective (see, e.g. Gottlieb et al., 2012). Scholars have emphasized how factors such as multilevel funding structures and privatized systems (McKeary and Newbold, 2010; Posner et al., 2002), separate health and registration bureaucracies (McKeary and Newbold, 2010), changing visa requirements (Briant and Kennedy, 2004), and fragmented personal support networks (Briant and Kennedy, 2004, p. 440) all change the calculus of healthcare access. Using an ethnographic approach and building on studies of comparative environments of access (e.g. Garcia-Subirats et al., 2014), we thus develop the concept of therapeutic geographies in a way that allows micro level experiences to inform macro understandings of the complex and discursive relationship between refugee life, humanitarian bureaucracy, political context, and healthcare access.

1.3. Methodology

Studying how Syrian refugees approach healthcare in Lebanon allows scholars to observe a case where the *politics of access* (Cammett and MacLean, 2011; Matthew, Burns, Mair, & O'Donnell, 2014) rather than the *presence or perception of services* (Pavlish et al., 2010; Singer and Adams, 2011) is a core factor in refugees’ healthcare experiences. This perspective allows researchers to build upon and further specify previous critiques of humanitarian practices conceptualized and developed in the Global North (de Waal, 2009; Kennedy, 2005; Terry, 2002) and to refine understandings of healthcare access by way of local immersion rather than a bird’s eye view. It also provides an important, humanizing complement to the population-level statistics that often drive policymaking.

As part of two broader projects focused on the evolution of Palestinian political organizations in Lebanon (Parkinson, 2013) and on Palestinian refugees’ development of aid programs for refugees from Syria, Parkinson conducted participant observation with Palestinian humanitarian providers working with refugees from Syria (both Syrian and PRS) in January and May–June of 2014. Building on nearly two years of interview-based, archival, and ethnographic research conducted between 2007 and 2014, including during May–June 2012 at the beginning of the current crisis, Parkinson spent this time living with a Palestinian family in a Beirut refugee camp. Having previously stayed in the camp and its environs, she interacted around-the-clock with old and new interlocutors, including her long-term Palestinian contacts, Syrian refugees and PRS who visited them, members of five Syrian families who lived in the same building, community members, and local volunteers.

This research approach allowed Parkinson to explore new categories and spaces of inquiry via the perspective of lifelong refugees (Palestinian refugees in Lebanon) as they interacted with refugee populations new to Lebanon (Syrians and PRS). Specifically, she witnessed informal interactions where Syrian refugees sought out their Palestinian neighbors’ help in answering questions (e.g. where the cheapest local pharmacy was), sharing advice (e.g. how to occupy young children in the absence of outdoor play spaces in the camp), or providing material and logistical help (e.g. accompanying them to renew paperwork with Lebanese General Security) (Parkinson, 2014a). Parkinson also interviewed Palestinian humanitarian workers and observed their interactions with refugees from Syria at a local non-governmental organization that hosted events such as community workshops and English language classes. These interactions gave Parkinson a grounded perspective on the challenges refugees from Syria confronted and the type of situated knowledge necessary to navigating quotidian life as refugee in Lebanon (Fiddian-Qasmiyeh et al., 2014).

Research was conducted under IRB Protocol 1312S46161 at the University of Minnesota, which details consent and confidentiality procedures. Research was conducted in the Levantine colloquial dialect without a translator. All interlocutors’ names are pseudonyms. The camp and hospital where Parkinson conducted participant observation are left unidentified to protect the people involved.

This approach achieves two specific goals. First, it explicitly highlights the fragmentary effect of aid regimes conceptualized in the Global North from the perspective of refugees themselves, emphasizing the way that Palestinian refugees act as sources of knowledge and social protection for Syrian refugees. Second, it sheds light on some of the multi-level challenges and paradoxes of healthcare access in the wake of violence while identifying important sources of resilience. More, it illustrates how humanitarian interventions in violent situations can simultaneously

spotlight and unintentionally perpetuate inequality and injustice (de Waal, 2009; Kennedy, 2005; Terry, 2002).

1.4. The politics of access: negotiating health and life in Lebanon

"I found him in the road," Um 'Umar tells Mo and I (Parkinson) when we meet in front of the Palestinian Red Crescent Society (PRCS) hospital. Ahmad, a Syrian refugee, is standing with the middle-aged grandmother and her adult daughter, looking deeply troubled. We already know part of the story from earlier WhatsApp messages. Ahmad's wife, Muntaha, is in labor; they are both Syrian refugees from Aleppo.

Um 'Umar and Mo, both Palestinian refugees born in Lebanon and active in social associations, immediately assess Ahmad's situation in terms of legal and financial ramifications. Asking about the couple's registration status allows them to quickly evaluate potential pros and cons of different access strategies. They ascertain that Muntaha is registered with the UNHCR while Ahmad is not. Mo, an employee of a major international aid organization in his mid-twenties, consequently relays that it would be cheaper for her to give birth in the Lebanese government hospital. Mo elaborates: if they go to a public Lebanese hospital, the couple will have to pay 25% of the bill, likely between LL199,000 and LL250,000 (US\$131 and US\$165); UNHCR will cover the rest. To give birth at the PRCS, by contrast, the couple would pay about LL500,000 (around US\$332); 50% of the cost would be covered by the hospital and the Palestine Liberation Organization (Parkinson, 2014a). These financial differences are significant; academic and aid organizations' studies have repeatedly shown that cost is a dominating factor in Syrian refugees' access to healthcare (Dewachi et al., 2014; Gulland, 2013).

Palestinian refugees in Lebanon are accustomed to weighing healthcare options in terms of necessity, quality, and price. Receiving subsidized care through a constellation of organizations including UNRWA (if they are registered), the PRCS, aid organizations, and Lebanese public hospitals makes them skilled at navigating segmented healthcare systems. Because these systems still often leave patients and their families with substantial bills, Um 'Umar and Mo are sensitive to cost considerations. In the road outside the PRCS hospital, these experiences become an important resource for Ahmad. The two Palestinians' approach—carefully presenting multiple options—and combined knowledge—e.g. of costs and facilities—shape how Ahmad decides what he and his wife will do.

During their careful, sensitive questioning, two other factors emerge: Ahmad's legal status and the network of security checkpoints on the way to the hospital. The government hospital is across the city whereas the PRCS hospital is walking distance to their rented room and within the comparatively safe confines of a camp. As Mo carefully outlines these options, Ahmad shares that he was recently detained by Lebanese General Security for working without a proper visa. They told him to obtain a labor visa for LL500,000; if he is caught outside of the Palestinian camp without it, he may face extortion, detainment, or deportation.

Evoking a common theme in the literature of healthcare access for refugees and migrants (Sargent and Larchanché, 2011, p. 348), the risk of encountering security forces proves a pressing concern for Ahmad, who expresses fear that the government hospital might check his identification. Mo tries calling the UNHCR information hotline for Syrian refugees to confirm the intake process and costs at the Lebanese hospital. He is greeted with a recording: "For English, press 1. For French, press 2. For Arabic, press 3." He bitterly notes that for a refugee from Syria, this process would waste precious credit from their limited account; he has already spent more than US\$1 before pressing his selection. He hangs up. Ahmad

decides that borrowing US\$200 for the government hospital fees is much easier than borrowing more than US\$300 for the PRCS. He also decides to remain in the camp rather than accompanying Muntaha.

Ahmad's experiences, uncertainties, and anxieties resonate with that of other refugees from Syria. Studies conducted by humanitarian organizations have found that refugees with limited legal status consistently report fear of crossing checkpoints as an impediment to healthcare access (Aranki and Kalis, 2014; Norweigan Refugee Council, 2014, pp. 15–19). Indeed, during Parkinson's field research in South Beirut, conversations about rules governing refugees' legal status, particularly with concern to the shifting rules governing entry and permit extension, surfaced nearly every day (Field notes, January 2014, May 2014, June 2014). For example, in a different camp, Ashraf, a PRS, explained that while he was supposed to go renew his *iqama* (residence card) he was afraid to get sent back to Syria; known as an activist, he was convinced that he would die if he returned even for a day. Ashraf then shared that he simply planned to stay in the Palestinian camp because he could not risk getting sent back (Field notes, May 27, 2014).

Ahmad brings Muntaha from their room and we help her into Um 'Umar's daughter's car for the drive. At the camp exit, Ahmad bids his wife goodbye and helps her sister, who will join us in Ahmad's place, into the car. As he closes the car door, Ahmad tells Mo that he will begin visiting his family and friends to gather donations for the hospital bills.

1.5. Exclusion through inclusion: lived experience as a frame for healthcare encounters

Mo and I take a separate cab to the hospital. When we arrive, a family from rural Syria—identifiable to Mo by their clothing and accents—is finishing a heated and visibly emotional conversation with a hospital employee. The prospective patient is a middle-aged woman; she is swaying and pale. Her eyes are unfocused. The conversation ends with the hospital employee shrugging and walking away. With concern, Mo postulates that they probably didn't have the money for a deposit and notes that the hospital staff is not supposed to be expelling refugees over their inability to pay.

Healthcare refusal was a headline-grabbing issue in Lebanon in late 2013 and early 2014. Within the same timeframe, many poor Lebanese were also being denied access to health services at public hospitals due to political disputes in the Ministry of Health (as-Safir, 2014; Lebanon Files, 2014). Scholars such as Sibai and Sen (2006, p. 848) have also long argued that Lebanon's healthcare system has "little interest in the poor" and is focused on (profitable) curative rather than primary care. However, the complexities of Syrian refugee life—registration, work permits, geographically fragmented families—interact in unique ways with this context and point to a specific politics operating within humanitarian structures.

The way that refugees' broader lived experiences feed into this politics of access is evident as Muntaha navigates the hospital system. When the car with Muntaha arrives, we walk through the deserted hospital lobby and through heavy doors marked "Emergency." We reach a counter; five doctors and nurses are casually arranged on chairs and desks, gossiping behind the partition. Mo takes the lead, explaining that we have a woman in labor with us. Disinterestedly, they wordlessly point us to an elevator bank. No one asks if Muntaha is able to walk or offers her a wheelchair.

Our party reaches the 2nd floor and weaves into the obstetrics waiting room. There is one row of unmovable, black, molded plastic bus station chairs and a vending machine; several women who are visibly in labor occupy the rigid chairs. Husbands stand, often

holding bags of spare clothing or clutching passports and family books (a form of formal Syrian documentation). The room is visibly unclean; there are cigarette butts, dirt, and trash on the ground.

We go looking for a nurse. Passing through a metal door, we face another counter. Mo greets the nurses behind it and explains that we have a woman in labor with us; the nurses look Muntaha up and down, registering her clothing, physical state, and facial features. Is there a room where we can bring her? Can she be examined? They're not sure if there's a room. They don't know where the doctor is. They'll check. Without looking at patient registers, computers, or into doorways, they then declare that nothing's open. They offer us no more information. We return to the waiting room.

Syrians and PRS often understood negative encounters such as these as part of a larger array of bureaucratic strategies being used to disincentivize their staying in Lebanon; no one in our party is surprised by these interactions. True or apocryphal, rumors in the camps often emphasized the harshness of the Lebanese healthcare apparatus and worked to construct Lebanese healthcare providers as actively working against refugees' interests, thus providing a common frame through which refugees understood their own subsequent experiences. For example, one particularly distressing rumor centered on a hospital in Sidon refusing to give the parents of a deceased Syrian infant his corpse for burial until they paid his hospital bill (Field notes, January 2014). Others emphasized that hospital billing offices would confiscate Syrians' papers if they could not pay; one version featured hospital employees in South Lebanon physically ripping up three refugees' papers (thus rendering them vulnerable to detainment and deportation) (Field notes, January 2014).

The theme of financial uncertainty reemerges as Mo continues to worry about the billing procedure. Unsurprisingly, given the rumors circulating, he and I had spent our cab ride worrying that Muntaha's papers might be confiscated by the hospital if she couldn't pay up front; I tell him that I'll accompany him to deal with the billing department. We don't want to bring Muntaha or her sister for fear of exposing them or having someone demand their papers. As a nurse directs us downstairs to billing, we watch others escort a Lebanese woman into an examination room. When we arrive at the elevator bank, a UNHCR poster elaborating the refugee insurance program hangs next to the elevators. Downstairs, the cashier tells us that "births start at LL250,000" and that our friend will have to pay a deposit ahead of time.

Um 'Umar's interim attention to the other families in the waiting room reveals one way that social interaction fundamentally interacts with therapeutic geographies. When we return, the waiting room is busy. Um 'Umar has been chatting with people and tells us that another family has just paid a LL550,000 deposit because they are not registered with UNHCR. Mo asks her to identify the couple, introduces himself, and asks them gently about their situation as I look over the bill to ascertain the nature and legitimacy of the charges. Mo gives them his mobile number and carefully outlines how the problem of being unregistered can compound itself; even if they are not registered with the Lebanese authorities, they must register the child. He walks them through this process: they must go to a *mukhtar* (neighborhood official) with their family book and the proof of birth from the hospital, pay a small fee and then go to the Lebanese government's civil affairs office to register the child in Lebanon. Their uncertainty shows how, for refugees from Syria in Lebanon, the simple matter of registering a child under these circumstances becomes a fraught bureaucratic endeavor involving multiple Lebanese government officials. The results, according to UNHCR, are worrisome: "A 2014 survey of 5779 newborns found that 72 percent do not possess an official birth certificate, raising concerns over the recognition of their nationality by the Syrian authorities" (UNHCR, 2015a).

A nurse tells Muntaha to go home and come back in the morning; she argues that because Muntaha "is not bleeding," the hospital cannot admit her. She ignores Muntaha's appeals that she did not bleed with any of her other four children. Driving into the camp, the soldier at the checkpoint demands all of our passports and IDs.

1.6. The mirage of care

These ethnographic vignettes shed light on the intersecting socioeconomic, political, and bureaucratic dynamics that shape healthcare access for refugees from Syria in Lebanon. They also reveal how knowledge of these types of dynamics ought to be incorporated into the concept of therapeutic geographies. For example, Muntaha's and Ahmad's initial predicament illustrates that the very procedures that have been put in place to facilitate care—in this case refugee registration and insurance contracting—may at once interact with other factors to hinder and/or discourage refugees' accessing healthcare services and expose them to more violence. Yet their ongoing negotiation of the situation also demonstrates how contingent local circumstances—such as the presence of an already established refugee community—shape the more recent arrivals' experiences as well as the situated knowledge they develop (Haraway, 1988).

In this case, Palestinian refugees' knowledge of available healthcare options, pricing, and security risks serve to inform what Ahmad and Muntaha decide. Their actions thus serve as a particularly important window onto the complex informal interactions that structure healthcare access—and provide sources of resilience—to vulnerable populations. As situated actors, and as refugees themselves, Um 'Umar's and Mo's evaluation of the situation is not simply about Muntaha's health, but about the potential for legal, social, financial, and emotional consequences of her decision to: 1.) Choose a Lebanese or Palestinian hospital for her delivery and; 2.) Leave the camp as a result. Mo, in particular, is aware of the fact that Ahmad runs an immense risk in order to accompany his wife; protecting Ahmad and his family is less of a question of healthcare availability (or quality) and more about weighing the risks that each option entails. Due to their role in accessing healthcare, these relationships thus constitute an important component of "therapeutic geographies."

Similar to Okie's (2007, p. 525) observations in the case of recent immigrants to the United States, "seeking health care often involves daunting encounters with a fragmented, bewildering, and hostile system." Crucially, though Muntaha's UNHCR registration entitles her to subsidized care, and though her visa status is current, the risk her husband and caretaker would shoulder in order to accompany her to the hospital changes their calculus. Though not directly health-related, these factors are central aspects of Syrian refugees' experience of healthcare (Gulland, 2013; International Rescue Committee & Norwegian Refugee Council, 2015; Norwegian Refugee Council, 2014).

To refugees from Syria, the hospital is far from a neutral care provider. Nor is a hospital visit an isolated occurrence. It is an ongoing process of negotiation and navigation within and through the constraints and uncertainties that shape their daily lives. Even the 25% financial obligation that accompanies any medical visit requires refugees to maintain financial reserves (difficult in harsh economic circumstances), borrow from friends and relatives, or to work (often illicitly or under discriminatory conditions). The interaction between health, financial instability, and visa requirements creates a complicated and potentially threatening environment. In this case, the hospital is a space where, due to the interaction of refugee status, hospital administration practices, and national politics, Ahmad and Muntaha are rendered vulnerable and

exposed.

Yet the hospital is also an institution operating in the broader context of Lebanese politics, where members of the cabinet and party leaders have publicly emphasized their desire to deport refugees from Syria and/or disincentivize further refugee flight to Lebanon (Hodeib, 2014; NOW Lebanon, 2013; The Daily Star, 2013). Foreign Minister Gebran Bassil, for example, has stated: “All this aid – be it food, shelter or health care – encourages Syrian refugees to stay in Lebanon, while what we want is to encourage their speedy exit” (Hodeib, 2014). Ministry of Education policies announced for the 2012–2013 and 2013–2014 school years convinced thousands of Syrian students who lacked “full” educational records (including three years of records stamped by the Syrian Ministry of Education and certified by the Syrian Ministry of Foreign Affairs in Damascus) that they were barred from taking advancement exams. Though exceptions were made, these policies were effectively a means of dissuading Syrian student enrollment (Parkinson, 2014b). In this socio-political context, the expulsion of visibly ill patients who cannot pay, the staff’s ambivalence in the emergency room, the obstetrics nurses’ dismissiveness, and the final, seemingly patronizing claim that a patient cannot be admitted because she “is not bleeding” all play into a broader narrative that Syrians are unwelcome and that they should “go home.”

Refusing or delaying care, along with care provision that is inseparable from humiliation and threat, emerges from larger political structures as a weapon of party and national politics (Abdelaaty, 2014). They are means of control, exclusion, and intimidation. Social, political, and economic instabilities such as unclear birth documentation requirements and churning rumor mills constantly shift the grounds of negotiation, forcing individuals to constantly re-evaluate and re-calculate their choices with regards to their health. Muntaha and Ahmad’s experience thus reveals how therapeutic geographies operate both *within* and *across* multiple social and policy domains and can be used as vehicles for political strategy and performance. It warns about probable implications of interactions between factors such as vulnerable visa statuses and poor health and social outcomes (Steel et al., 2011). Withholding care in these situations is not an instrument of war in the same way that refusing treatment to a wounded protester is (Dewachi et al., 2014). Rather, violence operates as a series of diffused moment fragments located in what anthropologists have called lived life (Behrouzan & Fischer, 2014; Behrouzan, 2015; Das and Cavell, 2006; Das, 2000; Kleinman et al., 1997). In a longer timeframe and across many refugee lives, the bureaucratic processes of registration and residency permission, combined with the subjective experience of daily life, disincentivizes seeking sanctuary in Lebanon.

2. Conclusion

Public health scholarship on humanitarian interventions frequently separates health from the intricacies of everyday refugee life by locating it solely in the structured/restricted space of the clinical encounter. Yet isolating these moments and assessing them in a vacuum fails to recognize health as integrated and experiential. In other words, access to health care needs to be situated in larger socio-political and economic structures that can exclude, divide, stigmatize, and privilege. The experiences and processes that characterize the politics of access create hierarchies of eligibility and deservingness (Gottlieb et al., 2012; Marrow, 2012; Sargent, 2012; Soss, 2002; Willen, 2012a, 2012b)—Lebanese versus Syrian, registered versus unregistered—and regimes of care that are contingent on shifting political realities.

Incorporating factors such as the bureaucratic uncertainties, social resources, and situated knowledge of refugee life into the

concept of therapeutic geographies is an important step in recognizing how therapeutic geographies operate on both transnational and micro-level scales. “Health-related” or not, these ostensibly mundane experiences are the building blocks of the very socio-political and medical conditions that humanitarian interventions and policy aim to address. To trivialize them would be to fail to address the problem at its core. Moreover, refusing to recognize the local socio-legal aspects of refugee life, may, in fact, expose refugees to more health risk. As Okie (2007, p. 526) argues, “laws and bureaucratic barriers that reduce ... use of key preventive health services, such as immunizations and screenings for infectious disease, make for bad public health policy.”

Developing the concept of therapeutic geographies across policy domains and investigating micro level dynamics helps scholars and practitioners to better understand the intersection of humanitarian service provision, national politics, and everyday refugee life (Dillon 2011; Kennedy, 2005; Terry, 2002; de Waal, 2009; Miller, 2014). Public health, development, and medical approaches to health have often focused on specific types of standardized outcomes (e.g. mortality and morbidity) thereby eclipsing situated forms of knowledge as well as unquantifiable implications of therapeutic interventions. Focusing solely on access, without addressing the social experience of healthcare, misses the point of humanitarianism altogether.

Future research should focus on the lived experience of both therapeutic and socio-political structures that shape access to health services (Sargent and Larchanché, 2011). More immediately, researchers can also evaluate how humanitarian initiatives such as cash aid programs, midwife trainings, and mobile clinic visits can be designed to simultaneously aid and protect populations such as Syrian refugees in Lebanon (Holmes, 2012). There are related lessons in the Ebola crisis in West Africa, where anthropologists have argued that the epidemic occurred despite and at times because of large scale investments in pandemic preparedness that privileged medical understandings over social interactions (Moran and Hoffman, 2014). In this light, Nguyen has proposed efforts that “stress community mobilization and care” in light of the important role that Ebola survivors play in caring for patients (Nguyen, 2014). These suggestions necessitate both inter-disciplinary as well as North-South dialogue that does not privilege certain know-how and knowledge practices over others; that is socio-politically situated; and that unpacks disciplinary and cultural assumptions to make concepts broadly accessible.

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